1301 Kemper Street
Post Office Box 797
Lynchburg, VA 24505-0797
Bus Information 434/847-7771 (TDO)
Main Office 434/847-5311
Maintenance Dept. 434/847-6341

Paratransit Eligibility Application

This is part of an application is for paratransit (van) services under the **Americans with Disabilities Act (ADA)**.

Form II: Health Care Professional Verification

To be completed by a physician or an approved health care professional only.

Please **PRINT** or **TYPE**. Use additional sheets if needed.
Complete all sections which are relevant to the applicant's disability(ies).

The Greater Lynchburg Transit Company (GLTC) provides paratransit services (door-to-door transportation provided in lift-equipped vans) to individuals who cannot utilize our fixed route service (our regular large bus system). To be eligible for this paratransit service, individuals must have one or more physical or mental disabilities which prevent use of the fixed route service. *Neither age, economic status, nor distance to the nearest bus stop by themselves constitutes eligibility.*

Please answer the following questions as they pertain to _____, who has asked us to forward this application to you on his/her behalf.

As a professional familiar with the applicant's medical history, please complete this form documenting the disability or condition that prevents his or her use of the regular bus system. Please assist us by certifying only those individuals that are truly unable to use the regular bus system.

A. General Information *Complete for all applicants.*

Capacity in which you know this person? _____

_____

What disability(ies) prevent(s) this person's use of a regular fixed route service? _____

_____

_____

_____

Form II: Health Care Professional Verification (cont.)

How does the disability(ies) prevent(s) the use of a regular fixed route service? Please be complete.

_____

_____

_____

Is this temporary? ❑Yes ❑ No **If "Yes", expected duration? _____**

B. Physical Mobility *Complete for applicants whose disability physically limits his/her mobility.*

Does this person use any of the following mobility aids:

- ❑ Manual Wheelchair
- ❑ Electric Wheelchair
- ❑ Powered Scooter
- ❑ White cane (for the visually-impaired)
- ❑ Crutches
- ❑ Walker
- ❑ Service Animal
- ❑ Walking Cane
- ❑ Portable Oxygen
- ❑ Personal Assistant/PCA
- ❑ Other _____

_____

If this person uses a riding mobility aid, how many blocks can he/she travel without help? (One block = approx. 500 ft.) **_____ block(s). How does this person's disability prevent him/her from traveling more blocks?** _____

_____

If this person uses a riding mobility aid (i.e. wheelchair or scooter), **can he/she get on and off of a wheelchair lift independently if our Fixed route servicees were equipped with lifts and handrails?** (Lifts would be operated by the drivers.) ❑Yes ❑ No **If no, explain why not.**

_____

If this person can walk, with or without a mobility aid, how many blocks can he/she walk without help? (One block = approx. 500 ft.) **_____ block(s). How does this person's disability prevent him/her from walking more blocks?** _____

_____

How many 9-inch steps can this person climb without help? _____

How does this person's disability prevent him/her from climbing more?_____

_____

Form II: Health Care Professional Verification (cont.)

If this person is unable to climb steps, could he/she stand, hold onto the handrails, and ride up into a bus on a wheelchair lift if our Fixed route servicees were so equipped? (Lifts would be operated by the drivers.) ❑Yes ❑ No **If "No", explain why not.** _____

_____

How many minutes can this person wait at a bus stop? _____

How does this person's disability prevent him/her from waiting longer? _____

_____

C. Cognitive Ability *Complete for applicants with a cognitive disability.*

Can this person read informational signs? ❑ Yes ❑ No **If "No", please explain.**

_____

_____

Can this person navigate independently? ❑ Yes ❑ No ❑ Sometimes
If "No" or "Sometimes", please explain. _____

_____

Can this person give his/her address, destination and telephone number upon request?
❑ Yes ❑ No ❑ Sometimes **If "Sometimes", please explain when.** _____

_____

Can this person recognize a destination or landmark? ❑ Yes ❑ No ❑ Sometimes
If "Sometimes", please explain when. _____

_____

Can this person ask for, understand, and follow directions? ❑ Yes ❑ No ❑ Sometimes
If "Sometimes", please explain when. _____

_____

Can this person deal with unexpected situations or changes in routine?
❑ Yes ❑ No ❑ Sometimes **If "No" or "Sometimes", please explain.** _____

_____

Form II: Health Care Professional Verification (cont.)

D. Visual Ability *Complete for applicants with a visual impairment.*

Can this person read informational signs? ❑ Yes ❑ No **If "No", please explain.**

_____

_____

Can this person navigate independently? ❑ Yes ❑ No ❑ Sometimes **If "No" or "Sometimes", please explain.** _____

_____

Has this person received mobility training? ❑ Yes ❑ No ❑Unknown

If "No", is this person on a waiting list to be mobility trained? ❑ Yes ❑ No ❑Unknown

If "Yes", approx. when will the training begin?_____

E. General Ability *Complete for all applicants.*

What specific weather conditions, if any, affect this person's mobility? Please explain completely.

_____

What terrain or road and sidewalk conditions, if any, affect this person's mobility?
Please explain completely. _____

Will this person require any assistance while traveling on our vehicle?
❑ Never ❑ Always ❑ Sometimes **If "Always" or "Sometimes", explain what, why and when.**

_____

_____

Will this person require a Personal Attendant/PCA while traveling on our vehicle?
❑ Never ❑ Always ❑ Sometimes **If "Sometimes", explain when.**

_____

Form II: Health Care Professional Verification (cont.)

Please describe any other functional limitation(s) affecting this person's mobility not described above. Be specific.

_____

_____

_____

_____

_____

_____

_____

_____

_____

In your professional opinion, does this applicant's disability prevent him/her from getting to or from, boarding, riding, or disembarking a regular Fixed route service?

❑ Yes ❑ No ❑ Sometimes

_____ _____

Signature of Health Care Professional Date

Name & Title:_____

Office Address:_____

City/State/Zip: _____

Office Telephone:_____

Return Completed form to:

GLTC

P.O. Box 797

Lynchburg, Virginia 24505

Attn: Eligibility Manager